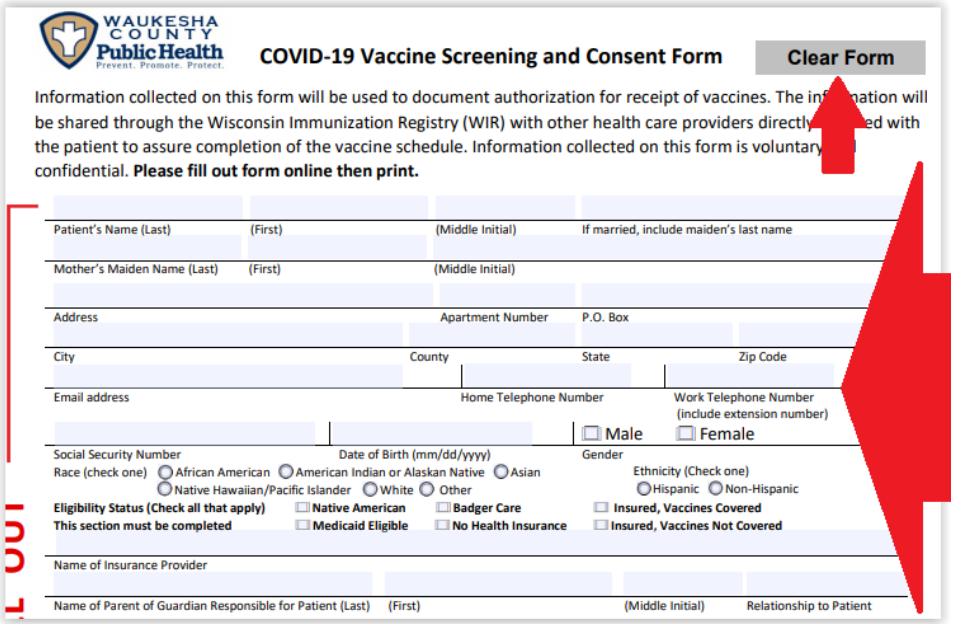
How To fill out COVID-19 Vaccine Screening and Consent Form

STEP 1

Locate and click each box to type your information as requested. Please fill out the form with as much information as you are able to provide. The “clear form” option in the top right will erase all entered information if clicked.



WAUKESHA COUNTY Public Health
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COVID-19 Vaccine Screening and Consent Form Clear Form

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please fill out form online then print.**

Patient's Name (Last) (First) (Middle Initial) If married, include maiden's last name

Mother's Maiden Name (Last) (First) (Middle Initial)

Address Apartment Number P.O. Box

City County State Zip Code

Email address Home Telephone Number Work Telephone Number (include extension number)

Social Security Number Date of Birth (mm/dd/yyyy) ☐ Male ☐ Female Gender

Race (check one) ◯ African American ◯ American Indian or Alaskan Native ◯ Asian ◯ Native Hawaiian/Pacific Islander ◯ White ◯ Other

Ethnicity (Check one) ◯ Hispanic ◯ Non-Hispanic

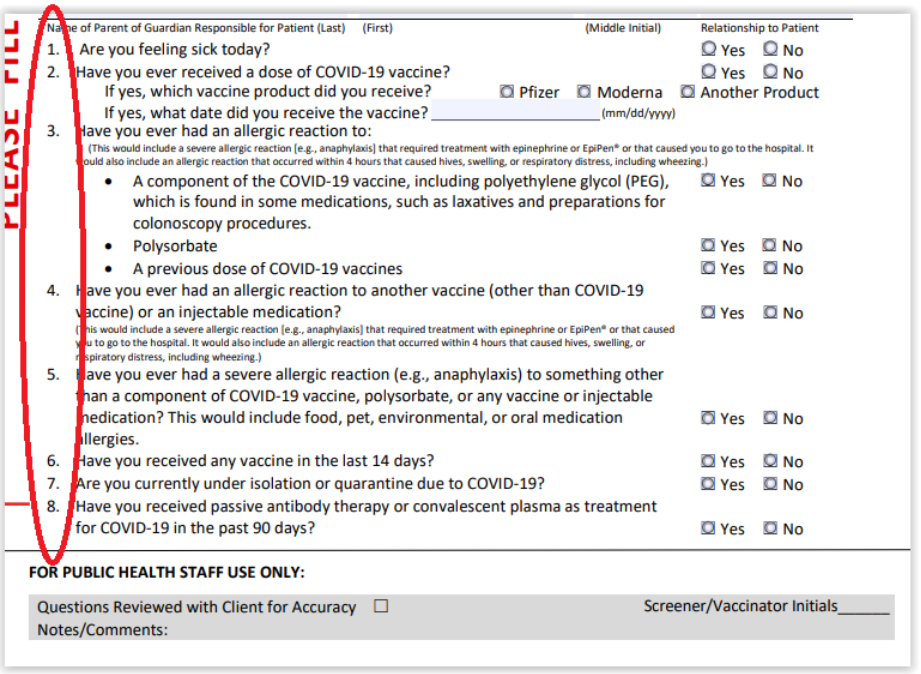
Eligibility Status (Check all that apply) ☐ Native American ☐ Badger Care ☐ Insured, Vaccines Covered
This section must be completed ☐ Medicaid Eligible ☐ No Health Insurance ☐ Insured, Vaccines Not Covered

Name of Insurance Provider

Name of Parent of Guardian Responsible for Patient (Last) (First) (Middle Initial) Relationship to Patient

STEP 2

Carefully read through and answer all (#1-#8) vaccine-specific medical questions.



PLEASE FILL

Name of Parent of Guardian Responsible for Patient (Last) (First) (Middle Initial) Relationship to Patient

1. Are you feeling sick today? ◯ Yes ◯ No
2. Have you ever received a dose of COVID-19 vaccine? ◯ Yes ◯ No
   If yes, which vaccine product did you receive? ◯ Pfizer ◯ Moderna ◯ Another Product
   If yes, what date did you receive the vaccine? _____ (mm/dd/yyyy)
3. Have you ever had an allergic reaction to:
   (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
   - A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures. ◯ Yes ◯ No
   - Polysorbate ◯ Yes ◯ No
   - A previous dose of COVID-19 vaccines ◯ Yes ◯ No
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? ◯ Yes ◯ No
   (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. ◯ Yes ◯ No
6. Have you received any vaccine in the last 14 days? ◯ Yes ◯ No
7. Are you currently under isolation or quarantine due to COVID-19? ◯ Yes ◯ No
8. Have you received passive antibody therapy or convalescent plasma as treatment for COVID-19 in the past 90 days? ◯ Yes ◯ No

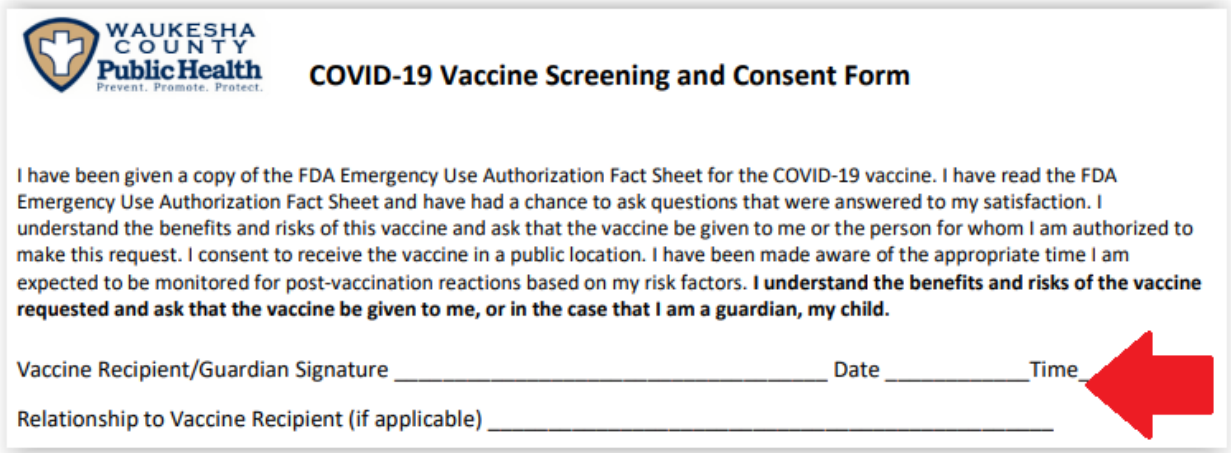
FOR PUBLIC HEALTH STAFF USE ONLY:

Questions Reviewed with Client for Accuracy ☐ Screener/Vaccinator Initials_____
Notes/Comments:

STEP 3

Sign and Date your consent form in the area provided.

Print your completed COVID-19 Vaccine Screening and Consent Form and bring with you to your scheduled vaccine appointment.



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COVID-19 Vaccine Screening and Consent Form

I have been given a copy of the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I have read the FDA Emergency Use Authorization Fact Sheet and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.**

Vaccine Recipient/Guardian Signature _____ Date _____Time_

Relationship to Vaccine Recipient (if applicable) _____